**GEORGIA DEPARTMENT OF COMMUNITY HEALTH**
**State Health Benefit Plan**
**Open Enrollment (OE) Election Correction Form**
**Employer must Fax to SHBP no later than December 31st at 1-866-828-4796**

**Please read the Terms, Conditions and Instructions on the back of this form prior to completing the form and submitting to your HR Department.**

**I. Member Identification** SSN ___ ___ ___ - ___ ___ - ___ ___ ___ ___ | ☐ Male ☐ Female | Date of Birth ____/ ____ /_____

Last Name _____ First _____ Middle Initial _____

Street Address _____ Apt/Box/Route _____

City _____ State _____ Zip Code (9 digits) _____

**II. Department/School System Use Only** Payroll Location Number _____ Unit/School _____

Event Date ____1_/__1____/_____ Date of Corrected Deduction _____/_____/_____

**I made the following Open Enrollment mistake:**
☐ **I made a mistake when choosing the Vendor** ☐ **I made a mistake when choosing the Option** ☐ **I failed to answer the Tobacco or Spousal Surcharge correctly**
☐ **I made a mistake and failed to add dependents listed below** ☐ **I made a mistake and failed to delete dependents listed below**
☐ **I made a mistake and failed to confirm my Discontinuation** ☐ **I made a mistake and failed to confirm my enrollment for coverage**

**IV. Please correct my Open Enrollment vendor or option election mistake with the following:** Choose one of the options below ☐ **Wellness (W)** ☐ **Standard (S)**

| **CIGNA** | | | **UNITED HEALTHCARE** | | | **TRICARE SUPPLEMENT - 88** |
|---|---|---|---|---|---|---|
| **W** | **S** | | **W** | **S** | | 100% of the cost is paid by member |
| ☐ C3 | C2 | Choice Fund (HRA) | ☐ U3 | U2 | HRA | ☐ 88 DEERS # _____ |
| ☐ C5 | C4 | Open Access Plus (HDHP) | ☐ U5 | U4 | HDHP | |
| ☐ C1 | C0 | Open Access Plus In Network (HMO) | ☐ U1 | U0 | Choice HMO | |

**V. Please correct my Open Enrollment mistake on Tobacco (Tob) Surcharge (SC) answers with the following:**
**A.** Have you or any of your covered dependents used any tobacco products in the previous 12 months?
☐ Yes - Tobacco surcharge will apply ☐ No – Surcharge will NOT apply
**B.** If you have used tobacco products in the last twelve months, have you completed the requirements under the SHBP Tobacco Cessation Policy?
☐ Yes The Tobacco surcharge will be waived ☐ No – The Tobacco Surcharge will apply

**VI. Please correct my Open Enrollment mistake on Spousal (Sp) Surcharge (SC) answers with the following:**

**Spouse Question #1:** Is your spouse eligible for health benefits coverage through his/her employment?
☐ Yes – Please answer Spouse Question #2 ☐ No - Surcharge will NOT apply skip to section VII
**Spouse Question #2:** Is your spouse enrolled in health benefit coverage through his/her employment?
☐ Yes – Surcharge will NOT apply skip to section VI ☐ No – Please answer Spouse Question #3
**Spouse Question #3:** Is your spouse eligible for SHBP coverage through his/ her employment?
☐ Yes – Surcharge will NOT apply - My spouse's employer is _____
☐ No – Spousal Surcharge will apply

**VII. Please correct my Open Enrollment mistake on Coverage Tier with the following:**
☐10 Employee ☐40 Employee + Tob SC ☐94 Employee + Child(ren) ☐95 Employee + Child(ren) + Tob SC
☐90 Employee + Sp ☐91 Employee + Sp + Tob SC ☐92 Employee + Sp + Sp SC ☐93 Employee + Sp + Tob + Sp SC
☐96 Employee + Sp + Child(ren) ☐97 Employee + Sp + Child(ren) + Tob SC ☐98 Employee + Sp + Child(ren) + Sp SC ☐99 Employee + Sp + Child(ren) +Tob Sp SC

**I made a mistake during Open Enrollment and failed to add (A) or Delete (D) the following dependents:**

**VIII. I have circled the A under Action to add a dependent, or have circled the D under Action to delete a dependent**

| Action (Circle) | Full name of spouse or eligible dependent(s) to be covered or deleted | | | Relationship (Circle) | Sex (Circle) | Date of Birth MO/DA/CCYR | Social Security Number **(Required) DO NOT HOLD FORM** |
|---|---|---|---|---|---|---|---|
| A D | _____ | | | SP NC SC LC | M F | _____/_____/_____ | __ __ __ - __ __ - __ __ __ __ |
| | Last Name | First | Initial | | | | |
| A D | _____ | | | SP NC SC LC | M F | _____/_____/_____ | __ __ __ - __ __ - __ __ __ __ |
| | Last Name | First | Initial | | | | |
| A D | _____ | | | SP NC SC LC | M F | _____/_____/_____ | __ __ __ - __ __ - __ __ __ __ |
| | Last Name | First | Initial | | | | |
| A D | _____ | | | SP NC SC LC | M F | _____/_____/_____ | __ __ __ - __ __ - __ __ __ __ |
| | Last Name | First | Initial | | | | |

(If adding a dependent, SHBP is now required to collect the Social Security Number. For dependents under age two, SHBP will provide coverage without the social security number upon receipt and approval of SHBP acceptable documentation. The vendors will not pay claims until the dependent verification documentation have been receive and approved by SHBP.

**VIII. Attestation: I made a mistake during Open Enrollment and request a correction due to this error.** I have read and agree to abide by the Terms, Conditions, Authorization and Instructions provided on the back of this form. I have also read and agree to complete the Wellness Promise for me and (my spouse – if covered) as outlined on the back of this form. I do hereby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that I may be subject to a fine of not more than $1,000 or imprisonment for not less than one and no more than five years, or both, if I knowingly and willfully make false or fraudulent statements or representation to the Department regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

Signature of Employee: _____ Date: _____

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**General Information**: Please review all State Health Benefit Plan (SHBP) communications and materials prior to completion of this form. Plan information is available on the SHBP web site at www.dch.georgia.gov/shbp. It is important that you understand your rights and responsibilities and that you carefully answer the surcharge questions if applicable. Failure to do so could have a financial impact on your premiums.

This form is to be used ONLY for active employees who made a mistake making their health election for 2012.

**Wellness Option:** If I enroll in a Wellness Option, I am making a Wellness Promise on behalf of myself and spouses if covered to: Each complete your online health assessment through your healthcare vendor and each obtain a biometric screening each year enrolled in a Wellness Option. The Screening includes Body Mass Index, Blood Pressure, Blood Glucose and Cholesterol.

You should read this side of the form and then complete Sections I, III, IV, V and Section VI if covering dependent(s). Incomplete forms **will not** be returned for completion. Read the Attestation in Section VIII carefully, then sign and date the form. The effective date of coverage is dependent upon the hire date and your payroll deduction for coverage. Refunds cannot be issued for incorrect or incomplete information. You will be bound to the Coverage Tier and Option selected and any applicable surcharges based on your answers to these questions.

**Surcharge Questions:**
*Spousal Surcharge* – will be added to your monthly premium if you elect to cover your spouse and he/she is eligible for coverage through his/her employment but chose not to take it. If your spouse is eligible for coverage with SHBP through his/her employment, the spousal surcharge will be waived, provided you answer the surcharge questions. If you fail to answer all of the applicable surcharge questions, you will automatically be charged the surcharge until the next Plan Year.
*Tobacco Surcharge* – A surcharge will be added to your monthly premium if you or any of your covered dependent(s) have used tobacco products in the previous 12 months. This includes dipping, chewing, smoking, etc.
**How to Remove Surcharge:** See Instructions on the SHBP Website www.dch.georgia.gov/shbp under the Active Employees column. The change in premiums will be effective based on the payroll deduction schedule of your employer. No refund in premium will be made for previous health deductions that included the surcharge amounts. IRS rules do not allow premium changes to be made retroactively.
**Dependents.** Be sure to circle the proper code in Section VII to describe the dependent's relationship to you and provide the documentation listed below. For additional information about eligible dependents, refer to the Summary Plan Description or Decision Guide at www.dch.georgia.gov/shbp.
**SP** – Spouse - Certified copy of marriage license or copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out.
**NC** – Natural Child - Certified copy of birth certificate or birth card issued by hospital listing parents by name is acceptable for new births); Adopted Child - Certified copy of court documents establishing date of adoption; certified or notarized legal documents establishing the date of placement for adoption if adoption is not yet finalized and certified copy of birth certificate or other proof of date of birth
**SC** – Step Child - Certified copy of birth certificate showing your spouse is natural parent and certified copy of marriage license showing natural parent is your spouse or copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out
**LC** – Legal Child - Certified copy of court documents stating the dates on which the legal guardianship begins and ends and a certified copy of the birth certificate or other proof of the child's date of birth.

**NOTE: Dependents will not be verified as having coverage until documentation and the social security number for each dependent (new federal law requirement) has been received and entered.** Children meeting SHBP eligibility requirements are eligible for coverage until the end of the month in which they turn 26. Coverage for a Disabled Child can be continued beyond age 26 if medical documentation is submitted to SHBP which meets SHBP disability requirements. The child must have been disabled before age 26.

**Penalties for Misrepresentation –** If a SHBP participant misrepresents eligibility information when applying for coverage, during a change of coverage or when filing for benefits, the SHBP may take adverse action against the participant, including but not limited to termination of coverage (for the participant and his or her dependents(s) or imposing liability to the SHBP for fraud or indemnification (requiring payment for benefits to which the participant or his/her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law. In order to avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law. Intentional misrepresentation in response to surcharge questions will have significant consequences. You and your covered dependent(s) will automatically lose SHBP coverage for 12 months beginning on the date that your false response is discovered.